STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	10/02/2014

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WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

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F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: September 24, 25, 26, 29, 30, October 1, and 2, 2014. Facility number: 000084 Provider number: 155167 AIM number: 100284600 Survey Team: Tom Stauss, RN-TC Beth Walsh, RN Geoffrey Harris, RN Tracina Moody, RN Karina Gates, Generalist Census bed type: SNF/NF: 118 Residential: 83 Total: 201 Census payor type: Medicare: 27 Medicaid: 57 Other: 34 Total: 118 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1 & 410 IAC 16.2-5.	F000000	Submission of this plan of correction shall not constitute or be construed as an admission by Westminster Village North that the allegations contained in this survey report are accurate or reflect accurately the provision of nursing care and service to the Residents at Westminster Village North.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed on October 7, 2014 by Cheryl Fielden RN.			
F000241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview, and record review, the facility failed to ensure residents at the same table were served at the same time for 9 of 20 residents observed eating in the dining room during 2 of 2 dining observations. (Residents #135, 30, 89, 112, 150, 65, 200, 103, and 156). The findings include: 1. On 9/24/14 from 12:14 p.m., to 1:00 p.m., dining was observed in the dining room. At 12:40 p.m., a food tray was delivered to Resident #135 who was sitting at a table with Resident #30. A food tray was delivered to another resident sitting by himself, and food trays were delivered to 2 residents sitting at a table together. Then a food tray was delivered to Resident #30. At 12:45 p.m., a food tray was delivered to Resident #89 who was sitting at a table	F000241	The Dietary Manager will discuss the issue with each individual resident noted to have been affected in the summary statement of this deficiency. However, please note, resident's #30, 65, and 112 are not noted on the list of "Resident Identifiers" given to the facility by the surveyors. Thus only 6 (six) residents could be identified as potentially affected. Staff will be in-serviced on the management of tray tickets to facilitate timely meal service, and, enhancing communication with residents regarding additional preparation time of special order items at point of selection and offering different menu items if this is not acceptable to the resident. The Dining and Food Service Policy and Procedure has been updated to reflect that meal delivery to residents in the dining room may be staggered (i.e., residents may be served at different times due to: 1) open dining service style/person centered dining such that residents may choose to	11/01/2014

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	with Residents #112 and #150. The next food tray was delivered to Resident #65 who was sitting with Residents #200, #103, and #156. An unidentified resident sitting by herself received her meal tray before Resident #103 received her tray. After Residents #112 and #156 received their meal trays, Resident #150 received hers at 12:55 p.m. At this same time during an interview, Resident #89 indicated to the residents at her lunch table it was unfair she had her food and was eating before the other 2 residents (#112 and #150) got their food. At the same time during an interview, CNA #7 indicated the nursing staff would put the meal tickets into the kitchen in the correct table order, but the residents did not receive the food trays back in the same order. During an interview on 9/29/2014 at 1:54 p.m., LPN #5 indicated she had seen residents wait for food trays while residents at the same table where already eating. She indicated the staff and dietary had been addressing the issues and it was getting better. She indicated, "Today, no one had to wait very long to receive a tray."		come to the dining room when they wish and eat wherever they choose 2) special order items are cooked fresh as they are ordered by residents and may therefore require additional preparation time compared to the standard daily menu items. In-services will be conducted to educate staff on the new policy and procedure. Staff will be trained to inform residents when additional time is anticipated for a resident's meal to be served due to special orders/requests etc. Additionally, if the resident prefers not to wait for the special order item to be prepared, the resident will be provided the opportunity to select something else from the menu. The revised policy and procedure will also be addressed at the next Resident Council meeting. By virtue of the fact that residents are offered a variety of choices, there will be instances where by all residents seated at any given table may not be served currently. In the event that a resident requests a cook to order selection or orders off the menu, and/or chooses to come to the dining room at their leisure, the resident will be offered a beverage and light snack (i.e. crackers) while waiting for his/her meal to be served. Daily meal rounds (on scheduled days of work) will be conducted by the Dietary Manager and/or Dietary Supervisors to assess meal delivery in the dining room.	

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	During an interview on 9/29/14 at 2:10 p.m., CNA #8 indicated the residents at the same table are supposed to get their food at same time like in a restaurant, but the dietary staff tends to mix up the tickets. She also indicated the tickets for one table were submitted at the same time, but the trays did not come back that way. During an interview on 9/30/2014 at 8:57 a.m., Dietary Manager #11 indicated residents at the same table would get their meals at the same time. On 9/30/14 at 9:12 a.m., Dietary Manager #11 provided the current policy and procedure entitled, "Dining and Food Service." The policy indicated the dining experience should, "enhance the individual's quality of life." 3.1-3(t)		These rounds/audits will be documented at the time the audit is conducted and the results will be forwarded to the administrator for review on a weekly basis. The Dietary Manager will communicate the results of said audits during the facility's monthly Quality Assurance Meeting. The written audits will be reviewed during the facility's monthly QA meetings for at lease six months. At the end of the six months the facility's QA team may choose to cease the monthly QA review if the audits reveal 100% compliance. The Administrator will monitor said compliance delineated above.	
F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes			

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	measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on interview and record review, the facility failed to have a care plan to address a resident's pain for 1 of 5 residents reviewed for unnecessary medications. (Resident #193) Findings include: The clinical record for Resident #193 was reviewed on 9/25/14 at 12:33 p.m. The diagnoses for Resident #193 included, but were not limited to, cancer. The 7/28/14 Admission MDS (minimum data set) assessment indicated Resident #193 had frequent pain and for her pain to be care planned. During review of Resident #193's care plans, no pain care plan was found.	F000279	It must be noted that resident #193 received appropriate pain management as evidenced by the surveyor's observation of the resident's medical record which reflected physician's orders for analgesia and administration of the same. Regrettably, the residents medical record lacked a care plan (a piece of paper) denoting established interventions to promote the residents comfort. As stated in the survey citing, a care plan was written for resident #193 at the time of discovery. Per the survey citation, data contained within the MDS was utilized to determine the need for a care plan regarding pain. Thus, the MDS data for the Health Center Residents will be audited in an effort to identify all other residents for whom a pain care plan is warranted. Care plans will then be reviewed to ensure that pain care plans are in place for all residents in need of	11/01/2014

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	The September, 2014 Physician's Orders indicated 2 caplets of 500 mg Tylenol to be taken every 6 hours as need for pain and 50 mg of Ultram (pain medication) to be taken every 6 hours as needed for pain. The September, 2014 PRN (as needed) Pain Medication Monitoring Flow Sheet for Resident #193 indicated she received prn pain medication 6 times from 9/10/14 to 9/25/14. An interview was conducted with the DON (Director of Nursing) on 9/26/14 at 12:28 p.m. The DON indicated Resident #193 did not have a pain care plan. An interview was conducted with the Quality Assurance Nurse on 9/26/14 at 1:45 p.m. She indicated, "I didn't find a care plan for pain, so I went ahead and did one. The care plan should have been done around admission." 3.1-35 (a)		the same. The Unit Coordinators will be responsible for this task. Additionally, the Medical Director of a local Hospice company is scheduled to provide a Pain Management in-service to our nursing management team and other interdisciplinary members on 10/29/14. Going forward, at the time of each MDS review, the MDS Nurses will ensure that a pain care plan is in place for all residents who are in need of the same. A written tool will be utilized on a weekly identifying resident's reviewed in conjunction with their MDS status regarding pain and will also review for the presence of a pain care plan if pain is triggered on the MDS. The MDS Nurses will present the results of their audits during the facility's monthly Quality Assurance Meetings for at least six months. At the end of six months the QA team may choose to cease the monthly QA reviews of the audits if the audit reveal 100% compliance. The Administrator will monitor said compliance delineated above.	
F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of			

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	care. Based on observation, interview, and record review, the facility failed to monitor a resident's dialysis access site daily for 1 of 1 resident reviewed for dialysis. (Resident #27) Findings include: The clinical record for Resident #27 was reviewed on 9/30/14 at 12:00 p.m. The diagnoses for Resident #20 included, but were not limited to, end stage renal disease. Resident #27's September, 2014 Physician's Orders indicated dialysis every Monday, Wednesday, and Friday. The orders indicated, "Remove pressure dressing from dialysis shunt to right leg 4 hours after dialysis." There were no other orders regarding a dialysis shunt site for Resident #27. Resident #27's September, 2014 Treatment Sheet indicated the order for the pressure dressing was done on the following dates: 9/1/14, 9/3/14, 9/5/14, 9/19/14, 9/24/14, 9/26/14, and 9/29/14. It indicated the order for the pressure dressing was not done on the following dates: 9/8/14, 9/10/14, 9/12/14, 9/15/14, 9/17/14, and 9/22/14.	F000309	A clerical error had occurred which resulted in the confusion regarding "right verses left". As noted by the surveyor, this was corrected at the time of discovery. As noted in the survey citing, the Unit Coordinator clarified the orders for this resident with the attending physician at the time of discovery. The resident's dialysis access site is now observed every shift. An audit will be conducted for all residents in the Health Center that require dialysis to ensure that physician's orders are in place addressing the frequency of the monitoring of the access site for signs/symptoms of infection. Educational material will be provided to the nursing staff to denote the signs and symptoms of infection for which one should be observant when assessing the dialysis access site. The Medical Director will be asked to review the facility's policy and procedure regarding dialysis. Any changes recommended by the Medical Director will be implemented. The Unit Coordinators will be responsible for daily (on their scheduled days of work) auditing of staff compliance with the monitoring of any access sites. An Administrative Nurse will do random audits of the aforementioned documentation until staff compliance is evident. The results of said audits/monitoring will be reviewed	11/01/2014

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	An interview was conducted with RN #23 on 9/30/14 at 12:57 p.m., regarding whether the pressure dressing order was followed for the above dates. She indicated, "I think her dressing is removed at dialysis before she comes back. I don't even think the fistula she has now even requires a dressing." An interview was conducted with Resident #27 on 9/30/14 at 2:45 p.m., regarding the location of her dialysis access site and whether nursing staff monitored her dressing daily. She pointed to her upper, left leg/groin area, and indicated it was the location of her dialysis access site. She indicated, "After I come back from dialysis, the nurses give me my medications and see how I'm feeling. They take my blood pressure and blood sugar when I come back from dialysis. The nurses look at my dressing a couple times a week. The nurses don't look three times a day, just a couple times a week." An interview was conducted with the DON (Director of Nursing) on 9/30/14 at 2:00 p.m. She indicated, "I'm looking for a dialysis policy. It's a standard nursing practice to take vitals after a resident returns from dialysis and to check the dressing every shift everyday."		during the facility's monthly Quality Assurance Meetings for at lease six months. At the end of the six months the QA team may choose to discontinue the monthly QA reviews of these audits if the audits reveal 100% compliance. The audits conducted by the Unit Coordinators and the Administrative nurses will be in writing. The Administrator will monitor for said compliance delineated above.	

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	An interview was conducted with RN #23 on 9/30/14 at 3:29 p.m., regarding how often nursing monitored Resident #27's dressing for signs and symptoms of infection. She indicated, "After she comes back from dialysis. It's kind of a protocol we made up, just to check it, just to cover us really." An interview was conducted with Unit Manager (UM) #17 on 10/1/14, at 10:00 a.m. She indicated, "The order for the right leg was supposed to come off in May, when she got the permacath. There's nothing we're supposed to do now for her permacath. The dressing gets changed every Monday, Wednesday, and Friday at dialysis....Nursing should observe for signs and symptoms of infection every shift. She had an infection in a previous access site before her permacath. She's had several access sites." Regarding when Resident #27 got her current permacath, UM #17 indicated, "I'm not sure exactly when that was. She's been here over 4 years. We did get new orders....I don't know what the expectation is for monitoring for signs and symptoms of infection and intact dressing. I just went ahead and had the order for every shift just to cover everything."			

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	The 10/1/14 Telephone Order for Resident #27 indicated to discontinue the dressing to her right leg dialysis shunt. Another 10/1/14 Telephone Order indicated, "Observe L (left) leg permacath/Dialysis for s/s (signs/symptoms) of infection and for intact dressing Q (every) shift." An interview was conducted with the DON on 10/1/14 at 10:51 a.m. She indicated, "I could not find our dialysis policy. I know we have one, so I typed this one up from memory." Regarding a lack of orders regarding Resident #27's access site monitoring, the DON indicated, "Typically the doctor will give specific orders for access site care. If the doctor doesn't give orders, we can ask the doctor or dialysis." The Dialysis, Coordination of Outpatient Services and Facility Services policy, provided by the DON on 10/1/14 at 10:45 a.m., indicated, "The nursing facility will monitor the status of the resident receiving dialysis for potential complications therewith." 3.1-37(a)			
F000311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS			

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	A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. Based on interview and record review, the facility failed to follow a restorative range of motion plan of care for 1 of 3 residents reviewed for rehabilitation. (Resident #8) Findings include: 1. The clinical record for Resident #8 was reviewed on 9/26/14 at 2:05 p.m. The diagnoses for Resident #8 included, but were not limited to, cervical spondylosis with myelopathy, generalized muscle weakness, and difficulty walking. A review of a Restorative Communication Form, dated 7/11/14, indicated range of motion (ROM) exercises to do for upper extremities and lower extremities. A Restorative ROM care plan, no date listed but remained current at time of review, indicated an intervention of, "Lower extremities: Enc [encourage] and instruct [name of Resident #8] with seated exercises...doing 2 sets of 20 with each exercise. Enc 6-7 times per week....Upper extremities: [sic] Flex and	F000311	The facility's Quality Assurance Nurse is responsible for the facility's Restorative Nursing Program. The Quality Assurance Nurse will review the Restorative Plan of resident #8 and the attending care plan. The facility's Quality Assurance Nurse will review all of the Restorative Plans/Care Plans for continued appropriateness for all residents and make any appropriate changes as needed. The facility's Quality Assurance Nurse will review Restorative documentation with the Restorative C.N.A.'s. The Quality Assurance Nurse will complete weekly audits of the Restorative documentation for continued appropriateness. The written audits will be presented during the facility's monthly Quality Assurance Meetings for a period of six months. At the end of six months the QA team may choose to cease the monthly review of these audits if the audits reveal 100% compliance. The Administrator will monitor for said compliance delineated above.	11/01/2014

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	extend...for 2 sets of 20 with each joint enc. to do 6-7 times per week." During an interview with Resident #8, on 9/29/14 at 10:19 a.m., Resident #8 indicated facility staff would do the ROM exercises 1-4 times a week. A quarterly MDS (Minimum Data Set) assessment, dated 8/29/14, indicated Resident #8 had a BIMS (Brief Interview of Mental Status) of 12, which was indicative of moderatively impaired cognition but interviewable. On 9/29/14 at 1:45 p.m., Restorative Aide/CNA #2 indicated she documented in the facility's computer tracking system when she performed the ROM exercises with Resident #8. A review of the Resident Restorative Chart (facility computer tracking system for ROM exercises) for 9/1/14-9/27/14 indicated the following: week 1 (9/1/14-9/6/14)=3 times [9/3/14, 9/5/14, 9/6/14] week 2 (9/7/14-9/13/14)=4 times [9/8/14, 9/9/14, 9/10/14, 9/11/14] week 3 (9/14/14-9/20/14)=3 times [9/15/14, 9/16/14, 9/18/14] week 4 (9/21/14-9/27/14)=1 time [9/25/14]			

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	A review of the ROM Detail Report (another report from the facility's computer system for ROM) indicated the same amount of ROM exercises for Resident #8 as above. During an interview with the Quality Assurance (QA) Nurse, on 9/29/14 at 2:55 p.m., she indicated the dates listed above were not reflective of the Restorative ROM plan of care for Resident #8. The QA further indicated staff was often pulled from restorative duties to "work on the floor or with activities." The QA nurse also indicated to perform ROM exercises 6-7 times a week might've been a little aggressive for Resident #8, but facility staff should've have done ROM exercises at least 5 times a week. 3.1-38(a)(2)			
F000323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure 4 of 8 housekeeping closets labeled "biohazard" were kept locked to prevent	F000323	During the inspection at the the time of discovery, all applicable doors were immediately audited to ensure that they were closed and locked. This practice continued throughout the survey	11/01/2014

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	potential accidents for 24 independently mobile and cognitively impaired residents on 2 of 4 units observed. (Residents #209, 51,95, 75, 14, 73, 89, 42, 139, 161, 200, 1, 93, 135, 115, 103, 111, 157, 84, 180, 43, 126, 150, 32). Based on observation, interview, and record review, the facility failed to follow physician's orders regarding the use of padded side rails for 1 of 3 residents reviewed for accidents. (Resident #91). Findings include: 1-A) On 9/24/14 from 10:00 a.m., to 10:30 a.m., the initial tour was conducted. A housekeeping closet labeled with a biohazard sign on the door was found unlocked in the unit next to the beauty salon. The following cleaning supplies were observed in the cleaning closet: spot remover, disinfectant, surface disinfectant wipes, odor remover, a stocked cleaning cart, a container of mop water, deodorizer sprays, hand soap, and floor cleaners. A housekeeping closet labeled with a biohazard sign on the door was found unlocked in the 3220's hall. The following cleaning supplies were observed in the cleaning closet: disinfectant wipes, hand soap, window cleaner, furniture polish, disinfectant		process. Our technicians removed the lock levers from the inside of all janitor closet doors throughout the health center and licensed residential buildings to prevent the doors from inadvertently being left unlocked. Please note that no residents were affected. Subsequently, an audit of all other doors was conducted, even the doors to areas containing non hazardous items. Adjustments were made to the doors as appropriate to ensure that the door could not be inadvertently unlocked. Going forward, the Manager of Environmental Services or designee will physically check the doors daily (on scheduled days of work) to ensure compliance in the health center and licensed residential areas. The Director of Campus Environment and Compliance will review the written audits on a weekly basis to ensure compliance. Maintenance personnel will be responsible for completing random checks on a weekly basis. The Plant Operations Director will be responsible for ensuring that maintenance personnel are physically checking the doors and will review the written audit log on a weekly basis. Bi-monthly inspections will be conducted by the Safety Committee of all housekeeping closets labeled "biohazard" to ensure compliance and will be documented on the safety Inspection form. The	

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	spray, floor cleaner in the mop sink, a stocked cleaning cart, and stainless steel polish. A housekeeping closet labeled with a biohazard sign on the door was observed unlocked in the 3210's hall. The following cleaning supplies were observed in the cleaning closet: window cleaner, disinfectant wipes, hand soap, acid disinfectant, urine remover, stain remover, floor cleaning soap in the mop sink, and a stocked cleaning cart. On 9/25/14 at 10:24 a.m., on 9/26/14 at 9:22 a.m., and on 09/26/2014 at 11:58 a.m., the housekeeping closet labeled with a biohazard sign on the door was observed unlocked in the unit next to the beauty salon. During each of the observations, the following cleaning supplies were observed in the cleaning closet: spot remover, disinfectant, surface disinfectant wipes, odor remover, a stocked cleaning cart, a container of mop water, deodorizer sprays, hand soap, and floor cleaners. During an interview on 09/30/2014 at 10:10 a.m., LPN #6 indicated there were sixteen residents on her two halls in the unit who had some level of cognitive impairment and were mobile.		responsibility of the auditor is to ensure proper operation of any door closure in that the door positively latches and remains locked into the frame. Training will continue of all existing staff at the annual OSHA Hazard Communications training and will also be covered in the facility training of all new hires. All staff has been educated about the need to ensure that janitor closets are to be locked at all times. The Manager of Environmental Services and Director of Plant Operations will report the status of the inspections at the monthly Quality Assurance meetings for at lease six months. At the end of six months the QA team may choose to cease the monthly review of these audits if the audits reveal 100% compliance. The Administrator will monitor for said compliance delineated above. The suspicioned area on the siderail was promptly covered with Coban, as observed by the surveyor. When the matter was reported to ISDH, the facility stated that the suspicioned area of the siderail would be "covered". Thus, the facility performed its due diligence to safeguard the resident. This Unit Coordinator, to her merit, believed that the addition of a side rail pad would further enhance the residents safety, as evidenced by the fact that she secured a physician's order for the same. However, if this Unit Coordinator was unable	

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	During an interview on 09/30/2014 at 10:20 a.m., LPN #5 indicated there were five residents on her hall in the unit who were cognitively impaired, and were mobile with the use of a wheelchair or walker. 1-B) On 9/29/14 from 10:00 a.m., to 11:00 a.m., the environmental tour was conducted with the Environmental Services Director, the Director of Plant Operations, Maintenance Manager, and the Director of Campus Environment. The housekeeping closet next to the beauty salon was observed to be unlocked. The door to the room was shut, had a key-pad lock panel above the doorknob, but the door was unlocked from the inside preventing the door key-pad from functioning. Inside the room were chemicals used by the housekeeping staff for cleaning. At the same time during an interview, the Maintenance Manager indicated that the door had been unlocked from the inside. The Maintenance Manager adjusted the latch on the inside of the door, pulled the door closed, and the door then locked. On 9/29/14 at 11:41 p.m., the housekeeping closet next to the dining room was observed to be unlocked. The door to the room was shut, had a key-pad lock panel above the doorknob, but the door was unlocked from the inside		to execute the order at the time, the physician should have been advised of the same. This was explained to this Unit Coordinator at the time of discovery. All other Unit Coordinators were advised of the same. This information will be made available to other licensed nurses. As noted by the surveyor, the side rail pads were added to the bed of Resident #91 at the time of discovery. Subsequent to this citing, the facility has purchased additional side rail pads. The charts of all Health Center residents will be audited in an effort to verify all residents with a current physician's order for siderail pad and the placement of the same shall be verified. The Unit Coordinators will continue to audit for the placement of the same on a daily basis (on scheduled days of work). Findings will be documented. Additionally, an Administrative Nurse will verify the appropriate presence of the same on a weekly basis. Findings will be documented. The results of said audits will be reviewed during the facility's Quality Assurance Meetings for a period of six months. At the end of six months the QA team may choose to cease monthly review of the audits if the audits reveal 100% compliance. The Administrator will monitor for said compliance delineated above.	

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	preventing the door key-pad lock from functioning. At the same time during an interview, Environmental Services Aide #15 indicated the housekeeping closet door was suppose to be locked when she was away from the door. Environmental Services Aide #15 was observed to return to the closet door, check the door to see if it was locked, attempted to use the lock code to lock the door, but the door failed to lock. She indicated the lock had been unlatched from the inside. She adjusted the latch on the inside of the door, pulled the door closed, and the door then locked. The Material Safety Data Sheets (MSDS) were provided by the Environmental Services Manager on 9/30/14 at 8:35 a.m. She indicated the following chemicals were kept in each of the housekeeping closets. These current MSDS indicated the chemicals and potential hazards included, but were not limited to: Disinfectant liquid. Hazard identification included, but were not limited to, corrosive, causes skin and eye burns, was harmful if swallowed and was combustible liquid and vapor. Restroom Disinfectant. Hazard identification included, but were not limited to, corrosive, causes irreversible eye damage and skin burns, was harmful if swallowed, and the inhalation of spray mist may cause respiratory harm or			

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	irritation. Stainless Steel Polish and Cleaner. Hazard information included, but were not limited to, eye contact, inhalation, skin contact, and ingestion. Concentrated Cleaner. Hazard information included, but were not limited to, causing eye irritation and may be mildly irritating to skin. Hand Sanitizing Foam. Hazard information include, but were not limited to, may cause eye irritation and may cause upset stomach or nausea. Disinfectant Spray. Hazard information included, but were not limited to, causes eye irritation and flammable. Foaming Disinfectant. Hazard information included, but were not limited to, may cause eye irritation. Glass and Multi-Surface Cleaner. Hazard information included, but were not limited to, corrosive, causes skin and eye burns,, and was harmful or fatal if swallowed. Foam Hand Cleaner. Hazard information included, but were not limited to, may cause eye irritation and may cause upset stomach or nausea. Foam Handwash with Skin Conditioners. Hazard information included, but were not limited to, may cause skin irritation and may cause upset stomach or nausea. On 9/30/14 at 9:57 a.m., a list of independently mobile and cognitively impaired residents was provided by			

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	Minimum Data Set (MDS) Coordinator. This list indicated the following Resident's #209, 51, 95, 75, 14, and 73. On 9/30/14 at 1:35 p.m., a list of independently mobile and cognitively impaired resident's was provided by LPN #2. This list indicated the following Resident's #89, 42, 139, 161, 200, 1, 93, 135, 115, 103, 111, 157, 84, 180, 43, 126, 150, and 32. A policy entitled "Safe Use Of Supplies And Equipment" and a document entitled "Housekeeping and Laundry Hazard Communication Training" was provided by the Environmental Services Manager on 9/30/14 at 8:35 a.m. This current hazard training document indicated "Chemicals not under direct observation must be locked up. Chemicals that are being stored must be behind a locked door that has chemical identification sign on exterior door". 2) The clinical record for Resident #91 was reviewed on 9/29/14 at 9:48 a.m. The diagnoses for Resident #91 included, but were not limited to, dementia. The 9/25/14, 11:50 a.m. progress note indicated, "res (resident) was found by caregiver...lying in her bed during bed check, aide alerted nurse that res had a skin tear to her her (sic) R (right) back			

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	hand between her ring and pinky finger, nurse observed a possible laceration to res R back hand measuring ...writer observed blood on res railing and on a screw located on res railing...adv (advised) to send res out for further eval..." The 9/26/14, 3:33 a.m., progress note indicated, "...ER nurse adv (advised) that res had to get 5 sutures in R hand...order for padding around railing to prevent future skin tears, will continue to monitor." The 9/26/14 Telephone Order for Resident #91 indicated, "Padded side rail on while in bed." The September, 2014 Treatment Sheet for Resident #91 indicated the above order was not done on 9/26/14, 9/27/14, or 9/28/14. An observation of Resident #91 in her recliner in her room was made on 9/29/14, at 10:10 a.m. No padding was observed on the side rails of her bed. An observation and interview was conducted with LPN #24 on 9/29/14 at 10:12 a.m. LPN #24 pointed to blue tape covering 2 areas on the right side rail of Resident #91's bed.			

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An interview was conducted with LPN #24 on 9/29/14 at 10:37 a.m., regarding the order for a padded side rail. She indicated, "I ordered her padded side rail. It's not in yet. That's why we wrapped it. I ordered it on 9/26 (9/26/14), when it happened. I order from the supplies people. Sometimes, they have it on hand, but didn't that day." LPN #24 left the nurses desk to check on the padded side rail from supplies. She returned at 10:57 a.m., and stated, "I checked supplies, and they don't have any. There's none on any of the units either."

On 9/29/14 at 11:01 a.m., LPN #24 was observed putting padded side rails on Resident #91's bed. She indicated, "I got them from the bathroom." After placing the padding, LPN #24 walked into the spa room down the hall, opened the closet door, and stated, "This is where I got them." Regarding whether the padding she just placed was the new padding she'd ordered on 9/26/14, she indicated, "These don't look new to me. The supply person came here on Friday (9/26/14), and said they didn't have any. I just now went ahead, and checked the closet in the spa room, and we had some, so I put them on. I didn't check the spa room closet on 9/26 (9/26/14)." Regarding checking the spa room closet

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	today and not previously, she indicated, "Because I had some extra time. The supply person is new so she's just learning." An interview was conducted with the DON (Director of Nursing) on 9/29/14 at 11:55 a.m. She stated, "I think since (Name of LPN #24) asked the supply person about it on the 26th, and we covered it with coban (tape), it was okay. But I see that, yes, we had the padding for the side rails in the building. The screw thing was a hypothesis on our part. We don't really know for sure how she got the tear." 3.1-45(a)(2)			
F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to			

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	treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on interview and record review, the facility failed to have supporting behavioral documentation to indicate the need to restart an anti-psychotic medication for 1 of 5 residents reviewed for unnecessary medication. (Resident #51) Findings include: 1. The clinical record for Resident #51 was reviewed on 9/29/14 at 2:05 p.m. The diagnoses for Resident #51 included, but were not limited to, senile dementia-Alzheimer type with depression, hypertension, and anemia. A Nursing Home Psychiatric Subsequent Visit Form, dated 5/16/14, indicated the, "...Treatment Plan: Overall mood is stable and no s/s [signs/symptoms] of psychosis so will attempt GDR [Gradual Dose Reduction] of Seroquel [anti-psychotic] to 25 mg [milligrams]... [symbol for times] 2 weeks then [sic] discontinue [the medication]...." A Progress Note, dated 7/17/14,	F000329	Resident #51 has been under the care of a psychiatrist for quite some time. Therefore, M.D. #20 is quite familiar with the resident as evidenced by the fact that M.D. #20 was able to relate to the surveyor, without hesitation, that resident #51 had experienced "increased paranoia and aggressive behaviors when resident #51's medication was discontinued", quoting from the survey citation. In other words the appropriateness of the medication used is not suspect, but rather the need was identified for enhanced documentation relative to the use of the medication. M.D. #20 is scheduled to assess resident #51 to evaluate the efficacy of the drug and determine if there is a need for the continued us of the same. The nursing staff will be provided with additional in-service education regarding behavioral documentation/management as it relates to the use of antipsychotics. The Social Services Director will speak with the Medical Director and the Nurse Practitioner in an effort to enlist their assistance in compliance with this citation. As prescribing medical practitioners,	11/01/2014

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	indicated, "Situation: Res has been noted to become easily tearful with occasional agitation. this [sic] am observed to eat pancakes and coffee for bkfst [breakfast]. When done staff attempted to bring res from dining room but she said 'But I haven't eaten or had my coffee' and put her head down and started to cry. This nurse reviewed with her that she did eat and have coffee and asked if she was still hungry and she replied 'No' and stopped crying. It has also been observed [symbol for times] 2 recently that res has become agitated with other res at dining table if she feels that they are sitting in her place [sic] become too close. [Name of Physician's office] contacted and NP [Nurse Practioner] will be in to make rounds in the am. Background: Seroquel tapered then dc'd in may [sic] per pharmacy review and recommendation...." A NP visit note, dated 7/18/14, indicated, "...Call center notes facility called [sic] reported 7/17 pt [patient/resident] has [symbol for increase] agitation and noted crying spells [symbol for with] confusion [sic] Pt was on Seroquel that was tapered then dc'd [discontinued] in May...Staff would like possible restart....1. Dementia [symbol for with] behaviors [symbol for increase] agitation inadequately controlled....start [symbol for and]		they will be requested to review supporting documentation when contemplating writing orders for antishychotic medications. The Pharmacy Consultant has been advised of this citation and will continue to monitor the documentation in this area. Subsequent to this citing, the Social Services Director will conduct written audit all residents that currently have orders for antipsychotic medications for appropriate documentation regarding the same. Ongoingly, said reviews will be conducted on a monthly basis by the Social Services Director and the findings shall be reviewed in the facility's Quality Assurance Meetings for a period of six months. At the end of the six months the QA team may choose to cease monthly reviews of the audits if the audits reveal 100% compliance. The Administrator will monitor for said compliance.	

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	resume Seroquel 25 mg daily Psych eval...." A review of the Behavior/Intervention Monthly Flow Records for May, June, and July 2014 indicated one behavior of crying on 7/17/14, as noted above. The Behavior Symptoms Detail Report for 5/3/14-7/31/14 did not indicate any behaviors for Resident #51. No other behaviors/incidents were documented in the clinical record during May through July. A list of any other behaviors that occurred in May through July was requested on 9/29/14 at 3:11 p.m., from Social Services Assistant (SSA) #31 During an interview with the Social Services Director, on 9/30/14 at 10:01 a.m., she indicated when a Resident would have a behavior or increased agitation, but was easily redirected, that behavior or agitation would not be a great concern and would not indicate a need to start an anti-psychotic medication. During an interview with the Quality Assurance (QA) Nurse, on 9/30/14 at 10:15 a.m., she indicated she did not recall many behaviors/issues with Resident #51. The QA Nurse indicated			

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	LPN #3 needed to be interviewed about Resident #51, since she takes care of Resident #51 quite often. On 9/30/14, at 10:24 a.m., LPN #3 indicated Resident #51 usually only had increased agitation or behaviors when someone would "invade" her space. LPN #3 further indicated Resident #51 was always easily redirected when she would have a behavior/agitation. LPN #3 also indicated she remembered when Resident #51 had her Seroquel discontinued and LPN #3 did not recall an increase in Resident #51's behaviors or agitation after the medication was discontinued During an interview, on 9/30/14 at 11:27 a.m., SSA #31 indicated the facility was not able to locate any other behaviors/documentation, during the months May through July, regarding increased behaviors/agitation for Resident #51 except for the incident described above on 7/17/14. SSA #31 further indicated one incident/behavior does not mean a Resident failed their GDR. At 12:40 p.m., on 9/30/14, NP #4 indicated she wrote the NP Visit note above. NP #4 indicated sometimes she often relies on facility staff to tell her about Resident's behaviors/agitation			

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	when she does not have time to review documentation or when she knows the facility staff fairly well. NP #4 further indicated one incident/behavior would not warrant an initiation of an anti-psychotic medication, especially if the resident was easily redirected. During an interview with MD #20, on 9/30/14 at 1:18 p.m., he indicated the facility did not have adequate documentation regarding behaviors to indicate the need for an anti-psychotic medication. MD #20 further indicated Resident #51 did have an increase in paranoia and aggressive behaviors when Resident #51's medication was discontinued. A policy titled, Psychoactive Medication Monitoring, no date, was received from the QA nurse on 9/30/14 at 1:30 p.m. The policy indicated, "...1. Residents receive a psychoactive medication only if supporting documentation is provided in the medical record...." 3.1-48(b)(1)			
F000441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to			

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	provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to properly disinfect a glucometer (machine used for readings of blood glucose/sugar levels) during random observations. This	F000441	As indicated in the citation, the facility's policy has been updated, denoting the need to consult the manufacturer's guidelines regarding the use of towelettes for disinfection of the Accucheck machine. Immediate in-service	11/01/2014

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	had the potential to affect 2 of 14 residents whom require glucometer readings. (Resident #31 and #21) Findings include: 1. During a random observation of blood glucose testing for Resident #31, with LPN #5 on 9/26/14 at 11:10 a.m., LPN #5 wiped the glucometer with a (Name of Company) Germicidal Disposable Wipe for approximately 10 seconds before performing the blood glucose testing. After the blood glucose testing was performed, LPN #5 wiped the glucometer with a (Name of Company) Germicidal Disposable Wipe for approximately 14 seconds and then placed the glucometer in the glucometer kit/holder. The glucometer did not remain visibly wet for 3 minutes after each time LPN #5 wiped the glucometer. A review of the packaging for the (Name of Company) Germicidal Disposable Wipes, indicated to disinfect, "...Unfold a clean wipe and thoroughly wet surface. Treated surface must remain visibly wet for a full three (3) minutes. Use additional wipe(s) if needed to assure continuous 3 minute wet contact time...." During an interview with LPN #5, on 9/26/14 at 11:17 a.m., she indicated there		instruction began regarding the revised policy. Additionally, informational signage was placed on each Accucheck container as a reminder. Also, timers were purchased and placed on each unit. We have since purchased a different type of towelettes which require less time, in an effort to expedite this process. Administrative Nursing staff will observe/audit random staff members for appropriate adherence to the policy and procedure regarding disinfection of the glucometers. This will be done weekly and the results will be documented. Any nurse observed to be deficient will be given an immediate 1:1 educational instruction. The results of said observations will be presented during the facility's Quality Assurance Meetings for a period of six months. At the end of six months the QA team may choose to cease the monthly reviews of the audits if the audits reveal 100% compliance. The Administrator will monitor for said compliance delineated above.	

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	were two glucometers that were used for all the Residents whom required blood glucose testing on that unit. 2. On 9/26/14 at 11:20 a.m., LPN #5 pulled out the above glucometer from the glucometer holder/kit, to perform blood glucose testing on Resident #21. LPN #5 proceeded to prepare the glucometer for blood glucose testing, by placing the blood glucose testing strip into the glucometer and wiping Resident #21's finger with an alcohol pad. LPN #5 picked up the blood glucose needle to obtain a sample of blood and was holding Resident #21's finger out to be pricked by the needle. LPN #5 was stopped from pricking Resident #21 finger. At 11:25 a.m., on 9/26/14, LPN #5 indicated she was only instructed the glucometer needed to dry 3 minutes between resident uses. LPN #5 indicated she was unsure on how long the glucometer needed to remain visibly wet while disinfecting the glucometer. LPN #5 then read the packaging for (Name of Company) Germicidal Disposable Wipes and proceeded to wipe the glucometer for 3 minutes before performing blood glucose testing on Resident #21. During an interview with Unit Manager/LPN #10, on 9/26/14 at 11:30			

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	a.m., LPN #10 indicated she was unsure how long a glucometer needed to be visibly wet when using the above wipe to disinfect the glucometer. LPN #10 further indicated she only knew the glucometer needed to dry three minutes between resident uses. On 9/26/14, at 11:45 a.m., the Director of Nursing indicated she was unsure on how long the glucometer needed to be visibly wet when disinfecting the machine, but the packaging should indicate a time. A policy titled, Performing a Blood Glucose Test with a Glucometer, dated 3/3/10, was received from the DON on 9/26/14 at 12:30 p.m. The policy indicated to, "...1. Cleanse the glucometer with an antiseptic towelette...." No time frame was located on the policy to indicate how long the glucometer needed to be wiped to disinfect the machine. The DON indicated at this time, the facility was revising their policy to indicate a time frame "per the directions on the towelettes." 3.1-18(a)			
F009999	Based on interview and record review,	F009999	The C.N.A. #16 is no longer employed by the facility. This	11/01/2014

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	the facility failed to prevent a staff member from working in the facility without a valid Certified Nursing Assistant license. This had the potential to affect all facility residents. Findings include: During a review of facility employee records on 10/1/14 at 1:06 p.m., CNA #16 was observed to have an out of state (Wisconsin) CNA (Certified Nursing Assistant) license. The employee records for CNA #16 did not show any license to practice as a CNA in the state of Indiana. On 10/1/14 at 1:50 p.m., during an interview, Human Resources Assistant # 26 indicated the facility Human Resources department found out in August of 2014 CNA #16's time to obtain a current and valid Indiana CNA license was running out. She indicated all CNA's should be licensed in Indiana by the end of 120 calendar days from the date of hire. She indicated CNA #16's hire date was 5/5/14 and the CNA should have had a valid CNA license by 9/5/14. She also indicated CNA #16 should not have worked in the facility after 9/5/14, but in fact did work on several other dates beyond 9/5/14. A facility timesheet for CNA #16		issue was identified by facility staff prior to surveyor identification. Upon this discovery, this employee was immediately taken off the schedule. This occurred as the result of humor error, as evidenced by the fact that ONLY one (1) of ninety-one (91) C.N.A. certificates were noted to have expired. Please note that facility staff was and continues to track C.N.A. certificates to ensure they remain current. However, this one C.N.A. was simply and inadvertently overlooked. Subsequent to the discovery of this oversight, the HR Assistant will audit all C.N.A. certificates for expiration dates on a weekly basis and advise the HR Director of any C.N.A. certificate that is approaching expiration. This will be documented on an audit form. The HR Director will confer with the C.N.A. prior to the expiration of the certificate. If the C.N.A. does not secure a valid C.N.A. certificate prior to the expiration date, the HR Director will advise the Staffing Coordinator that the employee must be removed from the schedule. The HR Director will present the results of the findings during the facility's Monthly Quality Assurance Meetings for a period of six months. At the end of six months the QA team may choose to cease the review of the audits should the audits reveal 100% compliance. The Administrator	

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	indicated she worked as a CNA on the dates of 9/6/14, 9/7/14, 9/8/14, 9/13/14, 9/14/14, 9/15/14, 9/20/14, 9/22/14, 9/27/14, 9/28/14, and 9/29/14. On 10/1/14 at 2:36 p.m., the Executive Director indicated CNA #16 was taken off of the schedule after 9/29/14 because of not having an current and valid CNA license. She indicated CNA #16 should not have worked as a CNA in the facility after 9/5/14 without a valid Indiana CNA license.		will monitor for said compliance delineated above.	
R000217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of			

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	services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to ensure a Resident signed a Service Plan. This affected 6 of 7 residents reviewed for clinical records. (Resident #'s 206, 218, 219, 275, 280, & 282) Findings include: 1) A list of interviewable residents was provided by the Manager of Residential Nursing on 9/30/14 at 2:45 p.m. Resident #'s 206, 218, 219, and 275 were on the list. Resident #219's record was reviewed on 10/1/14 at 9:44 a.m. Diagnoses for the resident included, but were not limited to, end stage renal disease, anemia, asthma, diabetes, and asthma. An Evaluation of Needs/Plan of Services for Resident #'s 219 was dated 9/2/14 and it remained current at the time of review. A review of the Service Plan Review page for the Evaluation of Needs/Plan indicated a signature for the Manager of	R000217	The facility will obtain signatures from Residents #206, 218, 219, 275, 280, and 282 on their most recent individual Plan of Service. The facility will receive the signatures on a semiannual basis from each resident going forward. The facility will audit each assisted living residents Plan of Service to ensure that a signature was secured. If a signature was not secured on the signature page, the facility will ensure that the appropriate resident signs their name on the signature page. The facility will also ensure that all signatures are obtained semiannually. The Residential Nurse Manager and all other staff responsible for obtaining the resident's signature on the Plan of Service will be educated regarding the state regulations and the need of this to be completed semi annually. The facility will update their policy on the Residential Plan of Service to include this specific piece of the regulation. The Residential Nurse Manager and/or Designee will monitor/audit all individual Plans of Service for all residents residing in Assisted Living. A monitoring/audit tool has been	11/01/2014

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	Residential Nursing MRN. 2) An Evaluation of Needs/Plan of Services for Resident #'s 206 was dated 6/2/14 and it remained current at the time of review. A review of the Service Plan Review page for the Evaluation of Needs/Plan indicated a signature for the Manager of Residential Nursing (MRN). On 10/1/14 at 10:42 a.m., the MRN indicated "we typically don't have the resident's or their families sign the service plans." 3) The clinical record for Resident #282 was reviewed on 10/1/14 at 11:15 a.m. The Signature Page of the September, 2014 Plan of Service for Resident #282 was not signed by Resident #282, even though there was a space for the resident signature. 4) The clinical record for Resident #280 was reviewed on 10/1/14 at 1:15 p.m. The Signature Page of the June, 2014 Plan of Service for Resident #280 was not signed by Resident #280, even though there was a space for the resident signature. 5) The clinical record for Resident #275 was reviewed 10/1/14 at 10:50 a.m. The diagnoses for Resident #275 included, but were not limited to,		created as a means to ensure that the signature of the resident has been obtained on a semi annual basis. The Residential Nurse Manager and/or designee will present the monitoring/audit tool in the monthly Quality Assurance Meeting. The written audit of the schedule for Plan of Service reviews are completed monthly to determine which residents are due to be reviewed and will ensure that the signature page is completed at the time of the review. The results of the audit will be reviewed during the facility's monthly QA meeting for at least six months. At the end of six months the facility's QA team may choose to cease the monthly QA reviews regarding the Plan of Service audits if the audits reveal 100% compliance. The Administrator will monitor said compliance delineated above.	

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	diabetes mellitus, peripheral neuropathy, and hypertension. An Evaluation of Needs/Plan of Services for Resident #275 was dated 7/24/14 and it remained current at the time of review. The Service Plan Review page for the Evaluation of Needs/Plan of Services indicated a signature for LPN #30. On the Resident Signature Line the statement, "reviewed [symbol for with] res [resident] score [symbol for equals] 60," was written on the line. 6) The clinical record for Resident #218 was reviewed 10/1/14 at 11:30 a.m. The diagnoses for Resident #218 included, but were not limited to, hypertension and osteoarthritis. An Evaluation of Needs/Plan of Services for Resident #218 was dated 9/20/14 and it remained current at the time of review. A review of the Service Plan Review page for the Evaluation of Needs/Plan indicated a signature for the Manager of Residential Nursing. On the Resident Signature Line the statement, "[symbol for no] changes [sic] reviewed [symbol for with] res [resident]," was written on the line. During an interview with the Manager of Residential Nursing, on 10/1/14 at 10:46			

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	a.m., she indicated the facility does not have the Residents sign their Service Plan. The Manager of Residential Nursing further indicated the facility only reviews the Service Plan with the Resident. A policy titled, Service Plan Development and Review Policy, no date, was received from the Manger of Residential Nursing, on 10/1/14 at 11:39 a.m. The policy did not indicate the facility was to obtain a signature from the Resident for the agreed upon Service Plan.			